CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

1. ORTHODONTIC SERVICES

(Procedures D1510, D1515, D1520, D1525, D8110, D8120) refers to an appliance necessary for the minor tooth movement or guidance of one or a few teeth. Payment applies to the appliance only. Diagnostic records and adjustment visits are presently outside the scope of covered benefits. Definitions of these procedures are as follows:

Fixed Space Maintainer

Definition: An appliance requiring cemented orthodontic bands with varying attachments such that patient removal or adjustment is difficult.

D1510 Fixed, Unilateral Type

Examples: a. Band and Loop
b. Cantilever type

D1515 Fixed, Bilateral Type

Examples: a. Soldered or adjustable lingual arch
b. Soldered or adjustable transpalatal arch
c. Cantilever type

Removable Space Maintainer

Definition: A space maintenance appliance which is readily removed by the dentist or the patient. The appliance may or may not have bands or stainless steel crowns.

Example: acrylic base appliance with or without clasps and/or teeth

D1520 Removable, Unilateral type
D1525 Removable, Bilaterial type

NOTE: D1510, D1515, D1520 and D1525 are used for the maintenance of existing intertooth space.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

D8110 Removable Appliance for Minor Tooth Guidance

Definition: An appliance, used for the positioning of one or a few teeth, that is readily removed by the dentist or patient.

Examples:
a. Hawley type with a variety of activating attachments
b. lip bumber with a variety of activating attachments
c. headgear with two molar bands and a facebow

D8120 Fixed or Cemented Appliance for Minor Tooth Guidance

Definition: An appliance requiring cemented orthodontic bands, with varying attachments for the positioning of one or a few teeth, such that patient removal or adjustment is difficult.

Examples:
a. diastema closing spring
b. adjustable lingual arch
c. adjustable transpalatal arch
d. crossbite correction (two bands and crossbite elastic)
e. segmented arch appliance (usually used for molar rotation and limited to one quadrant)
f. 2 X 4 or 2 X 6 appliance (involves two molars and four or six anteriors to correct anterior tooth rotation - limited to one arch)

TRANSITIONAL APPLIANCE

An acrylic or plastic appliance, so named because of its application during the period of transition from the primary to the permanent dentition; space maintenance or space management, and interceptive or preventive orthodontics.

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

DEFINITIONS OF DENTAL PROCEDURES

2. EXTRACTIONS

(Procedure D7110 and D7120) - apply to simple, uncomplicated extractions. Surgical extractions are outside the scope of covered benefits. Procedure D7110 is to be used to bill the first tooth extracted on a given day; all additional teeth extracted on the same day must be billed as procedure D7120.

CERTIFICATION FORM FOR INDUCED ABORTION OR INDUCED MISCARRIAGE

I, _____ , certify that on the basis of
(Physician's Name)

my professional judgement, the life of _____
(Patient's Name)

_____ of _____
(MAID #) *(Patient's Address)*

would be endangered if the fetus were carried to term. I further certify that the following procedure(s) was medically necessary to induce the abortion or miscarriage.

(Please indicate date and the procedure that was performed.) _____

_____

_____

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

MAP-235 (8-78)

CERTIFICATION FORM FOR INDUCED PREMATURE BIRTH

I, _____ , certify that on the basis of
(Physician's Name)

my professional judgement, it was necessary to perform the following procedure on _____
(Date)

to induce premature birth intended to produce a live viable child. _____
(Procedure)

This procedure was necessary for the health of _____
(Name of Mother)

_____ of _____
(MAID #) *(Address)*

and/or her unborn child.

_____
Physician's Signature

_____
Name of Physician

_____
License Number

_____
Date

KENTUCKY MEDICAL ASSISTANCE PROGRAM

DRUG PRE-AUTHORIZATION POLICIES AND PROCEDURES

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure is to provide Kentucky Medical Assistance Program (KMAP) recipients with access to certain legend drugs not normally covered on the KMAP Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. Such requests are referred to the Program by physicians, pharmacists, and social workers. Determinations are made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which can be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drug is to be used in lieu of hospitalization to maintain the patient on an outpatient basis and/or prevent a higher level of care.

2. The requested drug must be a legend drug. The only exception will be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition is maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.

3. The requested drug is to be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).

4. The requested drug will not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective."

5. Drugs on the formulary must have been tried, when appropriate, with documentation of ineffectiveness.

6. The Program will not pre-authorize the trial usage of a maintenance drug except when the drug has been tried for at least two weeks with successful results prior to the request. In such cases, when all criteria are met, retroactive pre-authorization for two weeks will be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines must be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics will be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six months.

2. Antibiotics

Requests for antibiotics will be considered ONLY if culture and sensitivity tests have identified specific sensitivity and/or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration will be given to the request.

3. Anti-Inflammatory Drugs (NSAID's)

Requests for anti-flammatory drugs will not be pre-authorized unless drugs on the Drug List have been tried unsuccessfully.

4. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Requests for "cough mixture" preparations such as expectorants and antitussives will not be pre-authorized. Only specified antihistamines may be pre-authorized if all other criteria have been met.

5. Chemotherapeutic Agents

Requests for anti-neoplastic agents will be considered for approved FDA indications.

6. Hypnotics and Sedatives

Requests for sedatives and hypnotics will be considered only after covered antidepressant and/or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also such requests must be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives will not be approved for more than two weeks, unless there is a diagnosis of terminal cancer.

7. Maintenance-Type Drugs

   Requests for maintenance-type drugs will be considered only if such drugs have been tried for at least two weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

8. Non-Legend Drugs

   Non-legend (over-the-counter) drugs will be excluded from coverage under drug pre-authorization.

   The only exception will be non-legend nutritional supplements as noted in I. A. 2. above and nicotinic acid.

9. Ophthalmics and Topical Preparations

   Requests for ophthalmics or topical preparations will not be pre-authorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

10. Tranquilizers, Minor

    Requests for minor tranquilizers will be considered only for acute anxiety, alcohol or drug withdrawal (with a one-month limitation), cancer, seizure disorders, and quadraplegia/paraplegia.

11. Ulcer Treatment Drugs, Legend

    On the basis of ulcer symptoms, legend ulcer treatment drugs may be pre-authorized if other applicable pre-authorization criteria are met.

12. Total Parenteral Nutrition

    May be pre-authorized if the need exists. Medicare maximum amounts allowed/month and maximum fees/month are applicable. The maximum amounts/fees allowed/month are subject to post payment review.

13. Transdermal Antihypertensive Medication

    Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient must remain the provider during the period of the pre-authorization unless a valid reason for change exists.

E. Pre-Authorization Period

The maximum period for which any drug may be pre-authorized will be six months. A request for renewal may be considered if the need for the drug continues to exist. Extensions may be backdated if the dates do not interfere with already existing segments on the drug file.

F. Minimum Cost Requirement

Only those requests for oral, non-liquid drugs which cost $5.00 or more to the pharmacy for a month's supply or a course of treatment will be considered for pre-authorization.

G. Routine Immunizations

Immunizations requested for routine health care will not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.

H. Exceptions to Existing Policy

The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.

II. THE REQUEST PROCEDURE

A. Initiating a Request

1. Requests for pre-authorization may be initiated by the prescribing physician or office personnel under his direct supervision. Requests from pharmacists and social workers who are working directly with the recipient's physician are also accepted.

2. The primary concern is that the caller have available the information necessary for staff to make an accurate determination.

B. Transmittal Methods

1. Written Requests

The drug pre-authorization request may be made IN WRITING to: EDS, P.O. Box 2036, Frankfort, Kentucky 40602.

2. Telephone Requests

Or by PLACING A TELEPHONE CALL to the following toll-free number between 8:00 a.m. and 4:30 p.m. EST/EDST, on Monday through Friday (except during holidays):
Telephone Number: 1-800-372-2944
Out of State: (502) 227-9073.

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications should provide information, line for line from the Pre-Authorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully. Primary Care Centers requesting a drug pre-authorization number should always give the provider number of the center as the provider and not the prescribing physician.

IV. DISPOSITION OF REQUEST

A. Nurses will review each request and make determinations on the basis of established Program criteria. Extenuating circumstances should be directed to the medical consultant.

B. If the appropriate information is received and the medication meets the Program criteria, an approval is made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request will be disapproved. Drug Pre-Authorization staff will NOT assume responsibility for calling physicians for more information.

C. Unusual or unique situations are reviewed by consultant pharmacists, physicians, and recognized University staff.

D. When the medication is not on the KMAP Drug List and is disapproved for pre-authorization, the recipient must assume responsibility for the cost or obtain an alternative source of payment.

E. Determinations will be made daily Monday through Friday, except on holidays.

V. NOTIFICATION OF DISPOSITION

A. Notification regarding the disposition (approval or disapproval) of each pre-authorization request will be made as follows:

1. DISAPPROVALS: When disapproved, the prescribing physician will be notified by mail. The request and reason for disapproval will be provided.

2. APPROVALS: When approved, notification will be made by phone to the selected pharmacy. The pharmacist will provide the pre-authorization staff with the NDC number and provider number.

   NOTE: Pre-authorization is not guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC #, MAID #, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.

B. Period of Coverage

The effective date for Program coverage of pre-authorized drugs will begin on the date the request is postmarked or date received by phone. Upon request, it is possible to allow up to a 10-day grace period on the beginning date. The pre-authorization will remain in effect for the specified time on the "Authorization to Bill" or until the recipient becomes ineligible, whichever comes first.

CAUTION: Pre-authorization does not guarantee payment.
Recipient must be eligible on date of service.
Verify by checking the recipient's Medicaid card.

VI. REIMBURSEMENT INFORMATION

A. Pre-authorized drugs will be reimbursed in the same manner as any other prescription drug entered on the MAP-7 claim form. The only addition to the claim form is the assigned pre-authorization number which is to be entered in Block #6 of the MAP-7 claim form. List the number as shown 0 0 0 0.

B. Private insurance companies, if applicable, must be billed prior to submitting claims for payment.

VII. ADDITIONAL INFORMATION

Any questions regarding the Drug Pre-Authorization Procedure should be directed to:

EDS
P.O. Box 2036
Frankfort, KY 40602

Telephone Number: 1-800-372-2944

Medicare Maximum Allowables
for Enteral/Parenteral Home Hyperalimentation

Description	Amount Allowed	
Compleat-B (liquid), 8 oz., per 24	$ 50.60	8 per month
Magnacal (liquid), 8 oz., per 24	50.60	8 per month
Vitaneed (liquid), 355 ml., per 24	50.60	8 per month
Criticare HN (liquid), 8 oz., per 24	81.35	10 per month
Compleat Modified (liquid), 8 oz., per 24	81.35	10 per month
Isocal HCN (liquid), 8 oz., per 12	26.20	8 per month
Meritene (liquid), 8 oz., per 24	26.20	8 per month
Sustacal (liquid), 8 oz., per 24	21.44	10 per month
Ensure (liquid), 8 oz., per 24	21.44	10 per month
Ensure Plus (liquid), 14 oz., per 6	21.44	10 per month
Osmolite (liquid), 8 oz., per 24	21.44	10 per month
Renu (liquid), 250 ml., per 24	21.44	10 per month
Isocal (liquid), 8 oz., per 24	21.44	10 per month
Travasorb whole protein, any flavor (liquid), 8 oz., per 24	21.44	10 per month
Vivonex HN (powder), 80 mg., per 10	45.68	31 per month
Precision HN (powder), 87.9 mg., per 10	45.68	31 per month
Travosorb Renal (powder), 112 gm., per 5	45.68	31 per month
Sustagen (powder), 5 lb., each	34.88	7 per month
Meritene (powder), 4.5 lb., each	34.88	7 per month
Precision isotonic (powder), 61.8 gm., per	17.28	31 per month
Travasorb STD, any flavor (powder), 83.3 mg., per 6	17.28	31 per month
Travasorb MCT (powder), 89 mg., per 5	17.28	31 per month
Flexical (powder), 60 mg., per 8	14.90	31 per month
Vivonex STD (powder), 80 mg., per 6	14.90	31 per month
Precision LR (powder), 90 mg., per 6	14.90	31 per month
Intralipids (500 ml.)	36.40	31 per month
Heparin (2 cc)	30.60	Monthly Maximum
Nutrient expander (saline, 500 ml.)	5.00	31 per month
Parenteral nutrients, 1 liter/day	79.31	31 per month
Parenteral nutrients, 2 litters/day	132.00	31 per month
Sustagen (powder), 1 lb, each	10.05	31 per month
Portagen (powder), 1 lb, each	10.05	31 per month
Meritene (powder), 1 lb, each	9.58	16 per month
Sustacal (powder), 54.5 gm., per 24	9.58	16 per month
Vital HN (powder), 78 gm., per 24	76.60	7 per month
Travasorb HN (powder), 83.3 gm., per 6	32.47	31 per month

DSS-115
R.7/87

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL SERVICES

APPENDIX XIX

CONFIDENTIAL
SUSPECTED ABUSE/NEGLECT, DEPENDENCY OR EXPLOITATION REPORTING FORM

TYPE REPORT: ☐ Child ☐ Adult ☐ Spouse County of Report _____ Time Report Received _____

Report Date _____ Incident Date(s) _____

1. Name(s)

	Age	Sex	Nature of Report
a. _____	____	____	☐☐☐☐
b. _____	____	____	☐☐☐☐
c. _____	____	____	☐☐☐☐
d. _____	____	____	☐☐☐☐
e. _____	____	____	☐☐☐☐

CHILD: 1. Physical Injury 2. Sexual Abuse 3. Mental Injury 4. Neglect 5. Dependency

ADULT: 6. Adult Abuse 7. Spouse Abuse 8. Self-Neglect 9. Caretaker Neglect 10. Exploitation

2. Current Address _____
Street/Rural Route City/Zip County Telephone #

3. Directions _____

4. Parent(s) /Guardian/Caretaker _____ Relationship _____

5. Other Known Household Members _____

6. Describe nature/extent/causes of abuse/neglect/dependency, or exploitation. List witnesses and/or collateral contacts,previous incidents or reports. Describe behavior of adult victim and of alleged perpetrator (dangerous?)

_____

_____

_____

_____

7. Alleged Perpetrator, if different from 4 above

Name _____ Relationship _____

Address _____
Street/Rural Route City/Zip County Telephone #

8. Person Taking Report _____ Title _____

9. Worker Assigned to Investigate _____ County _____ Telephone # _____

by: Family Services Office Supervisor _____

10. ATTENTION: LAW ENFORCEMENT ☐ Certification of Receipt of Report on Form JC-3 or by Other Law Enforcement Means.

Kentucky Revised Statutes, Chapter 620.030 and/or 209.030(2), dealing with suspected child physical or sexual abuse and suspected adult abuse, neglect, exploitation, or spouse abuse requires the Department for Social Services to notify the appropriate law enforcement agency.

INTERVENTION REQUESTED ☐ ☐ At your discretion

Sent to: _____ , County Attorney

11. Person Making Report _____ Title/Relationship _____

Address _____
Street/Rural Route City/Zip County Telephone #

TABLE OF CONTENTS

		PAGE NO.
I.	INTRODUCTION	
	A. Introduction	1.1-1.2
	B. Fiscal Agent	1.1
II.	KENTUCKY MEDICAID [~~MEDICAL ASSISTANCE~~] PROGRAM [~~KMAP~~]	2.1-2.8
	A. General Information	2.1
	B. Administrative Structure	2.2
	C. Advisory Council	2.2-2.3
	D. Policy	2.3-2.5
	E. Public Law 92-603	2.5-2.8
	F. Timely Submission of Claims	2.8
III.	CONDITIONS OF PARTICIPATION	3.1-3.7
	A. Definition and Intent	3.1
	B. Participation Requirements	3.2-3.5
	C. Termination of Participation	3.5-3.7
IV.	SERVICES COVERED	4.1-4.101
	A. Basic Services	4.1-4.2
	B. Supplemental Services	4.2
	C. Non-Covered Services	4.3
	D. Medical	4.3-4.25
	E. Laboratory	4.26
	F. Dental	4.27-4.42
	G. Family Planning	4.43-4.52
	H. Pharmacy	4.53-4.61
	I. Clinical Pharmacist	4.61
	J. Audiology	4.62-4.71
	K. Vision	4.72-

TABLE OF CONTENTS

	PAGE NO.
V. REIMBURSEMENT	5.1-5.5
A. Method of Reimbursement	5.1
B. Medicare, Title XVIII Coverage	5.2
C. Reimbursement in Relation to Other Third-Party Coverage	5.2-5.5
D. Duplicate or Inappropriate Payments	5.5
VI. COMPLETION OF INVOICE FORM	6.1-6.5[~~7~~]
VII. REMITTANCE STATEMENT	7.1-7.5
A. General Information	7.1
B. Section I -- Claims Paid	7.2-7.3
C. Section II -- Denied Claims	7.3
D. Section III -- Claims in Process	7.4
E. Section IV -- Returned Claims	7.4
F. Section V -- Claims Payment Summary	7.4-7.5
G. Section VI -- Description of Explanation Codes	7.5
VIII. GENERAL INFORMATION -EDS	8.1-8.7
A. Correspondence Forms Instructions	8.1
B. Telephone Inquiry Information	8.2
C. Filing Limitation	8.3
D. Provider Inquiry Form	8.4-8.5
E. Adjustment Request Form	8.6-8.7

TABLE OF CONTENTS

PRIMARY CARE SERVICES APPENDIX

Appendix I -Medicaid [~~KMAP~~] Services
Appendix II -Eligibility Information
Appendix II-A -KMAP MAID Card
Appendix II-B -KMAP Lock-In Card
Appendix III -KMAP Provider Agreement (MAP-343)
Appendix IV -Provider Information Sheet (MAP-344)
Appendix V -Statement of On-Site Services and Referral Arrangements (MAP-231)
Appendix VI -Certification of Conditions Met (MAP-346)
Appendix VII -Statement of Authorization (MAP-347)
Appendix VIII -Health Insurance Claim Form (HCFA-1500) (12/90)
[~~Primary Care Billing Form (MAP-7)~~]
Appendix IX-A -Paid Claims Remittance Advice
Appendix IX-B -Denied Claims Remittance Advice
Appendix IX-C -Claims in Process Remittance Advice
Appendix IX-D -Returned Claims Remittance Advice
Appendix IX-E -Description of Explanation Codes
Appendix X -Provider Inquiry Form (EDS)
Appendix XI -Adjustment Request Form (EDS)
Appendix XII -Third Party Liability Lead Form
Appendix XIII-A-Sterilization Consent Form (MAP-250)
Appendix XIII-B-Instructions for Use of MAP-250
Appendix XIV-A -Hysterectomy Consent Form (MAP-251)
Appendix XIV-B -Instructions for Use of MAP-251
Appendix XV-A -Prior Authorization for Vision Care (MAP-8)
Appendix XV-B -Instructions for Use of MAP-8 Form
Appendix XVI -Definitions of Dental Procedures
Appendix XVII-A-Certification Form for Induced Abortion or Induced Miscarriage
Appendix XVII-B-Certification Form for Induced Premature Birth
Appendix XVIII -Drug Pre-Authorization Policies and Procedures
Appendix XIX -Report of Suspected Child Abuse/Neglect (DSS-115)

SECTION VI - COMPLETION OF INVOICE FORM

VI. COMPLETION OF INVOICE FORM

A. General

The Health Insurance Claim Form (HCFA-1500) (12/90) [~~Primary Care Invoice (MAP-7)~~] shall [~~must~~] be used to bill for all primary care services rendered eligible Kentucky Medicaid [~~Medical Assistance~~] Program recipients. A[~~n~~] claim or invoice is to be completed to reflect all services rendered a recipient on a given date, even when the services do not constitute a "billable service." A definition of billable service may be found in Section V - Reimbursement, and in the Reimbursement Manual, PART I, Section 103, page 3.01.

The original of the two part invoice set shall [~~should~~] be submitted to EDS as soon as possible after the service is provided. The carbon copy of the invoice shall [~~should~~] be retained by the provider as a record of claim submitted.

Invoices shall [~~should~~] be mailed to:

EDS
P.O. Box 2018 [~~64~~]
Frankfort, Kentucky 40602

B. Completion of the Health Insurance Claim Form, HCFA-1500 (12/90) [~~Primary Care Invoice~~]

An example of a Health Insurance Claim Form, HCFA-1500 (12/90) [~~Primary Care Invoice~~] is shown in the appendix. Instructions for the proper completion of this form are presented below.

IMPORTANT: The patient's Kentucky Medical Assistance Identification Card shall [~~should~~] be carefully checked to see that the patient's name appears on the card and that the card is valid for the period of time in which the medical services are to be rendered. There can be no Medicaid [~~KMAP~~] payment for services rendered to an ineligible person.

The age of the patient will also be reflected on the Identification Card. This shall [~~should~~] be noted, specifically in cases where the patient requires services that are limited to recipients UNDER the age of 21.

SECTION VI - COMPLETION OF INVOICE FORM

HCFA-1500 (12/90) forms may be obtained from:

U.S. Goverment Printing Office
Superintendent of Documents
Washington, D.C. 20402

Telelphone: 1-800-621-8335

BLOCK NO.	ITEM NAME AND DESCRIPTION
2	PATIENT'S NAME Enter the recipient's last name, first name, middle initial exactly as it appears on the current Medical Assistance Identification (MAID) card.
9A	OTHER INSURED'S POLICY OR GROUP NUMBER: Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.
10B,C	ACCIDENT: Check the appropriate block if treatment rendered was necessitated by some form of accident.
11	INSURED'S POLICY GROUP OR FECA NUMBER Complete if the recipient has any kind of private heatlh insurance that has made a payment, other than Medicare.
11C	INSURANCE PLAN NAME OR PROGRAM NAME Enter the name of the insurer and the policy number.
19	INSURED'S GROUP NUMBER Enter the recipient's ten digit Medical Assistance Identification (MAID) number exactly as it appears on the current MAID card.

[BLOCK NO. ITEM NAME AND DESCRIPTION

1 RECIPIENT LAST NAME:

Enter the last name of the recipient EXACTLY as it appears on his/her current Medical Assistance Identification (MAID) card.

2 FIRST NAME:

Enter the first name of the recipient EXACTLY as it appears on his/her current MAID card.

3 M. I.:

Enter the middle initial of the recipient.

4 MEDICAL ASSISTANCE I.D. NUMBER:

Enter the recipient's identification number EXACTLY as it appears on his/her current MAID card. The number consists of 10 digits and all of them most be entered.

5 EMERGENCY:

Check box provided if the treatment rendered recipient was necessitated by some form of emergency.

6 PRIOR AUTHORIZATION:

If the service rendered required prior authorization by the Cabinet, enter the authorization number assigned by EDS.

7 SCREENING RELATED SERVICES:

Check box provided if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment examination.]

SECTION VI - COMPLETION OF INVOICE FORM

21 DIAGNOSIS CODE

Enter the appropriate ICD-9-CM diagnosis codes. Does not apply to pharmacy and non-emergency dental services.

23 PRIOR AUTHORIZATION NUMBER

If the service provided requires prior authorization, enter the prior authorization number assigned by EDS.

24A DATE OF SERVICE

Enter the date on which each service was rendered in month, day, year sequence, and numeric format. For example, April 16, 1992 would be entered as 04-16-92.

24B PLACE OF SERVICE

Enter the appropriate place of service code from the list on the back of the claim form identifying where the service was provided.

24D PROCEDURE CODE

Enter the procedure code which identifies the service or supply rendered to the recipient. For pharmacy claims, enter the twelve (12) digit NDC number.

24E DIAGNOSIS CODE INDICATOR

Transfer "1", "2" or "3" from the field 21 to indicate which diagnosis is being treated. Do not enter the actual diagnosis code in this field.

[8 REFERRING PRACTITIONER: - Required for all referrals

For KenPAC and Lock-In recipients who are referred to the center, enter the 8-digit KMAP number of the referring KenPAC or Lock-In provider. All other referrals enter either the name or KMAP provider number of the referring physician.

9 HEALTH INSURANCE:

If the recipient has any kind of health insurance, other than Medicare, enter the name and address of the insurer and the policy number.

10 ICD-9-CM DIAGNOSIS CODE: Required (except for the drug and non-emergency dental services)

(1) First Diagnosis - enter the ICD-9-CM code on the right side of the MAP-7 in the Leave Blank area.

(2) Second Diagnosis - enter the ICD-9-CM code on the right side of the MAP-7 in the Leave Blank area.

11 INDICATE SERVICES FOR EPSDT (SCREENING) REQUIREMENTS:

Enter code as appropriate in each box for service rendered. Codes for Blocks #11 and #12 are as follows:

A - Normal
B - Abnormal, referred
C - Abnormal, under treatment

Leave Blank if service was not indicated for child's age and health history.]

SECTION VI - COMPLETION OF INVOICE FORM

24F PROCEDURE CHARGE

Enter your usual and customary charge for the service rendered.

24G DAYS OR UNITS

Enter the number of times this procedure was provided for the recipient on this date of service. For pharmacy services, enter the drug quantity of each prescription billed.

24H EPSDT Family Plan

Enter a "Y" if the treatment rendered was a direct result of an Early and Periodic Screening, Diagnosis and Treatment Examination.

24K RESERVED FOR LOCAL USE

When billing pharmacy services, enter the prescription number. When billing dental services, enter the tooth number(s). Enter the vaccine dose for vaccinations. Enter the EPSDT referral codes, if applicable, for EPSDT.

26 PATIENT'S ACCOUNT NO.

Enter the patient account number, if desired. EDS will key the first seven or fewer digits. This number will appear on the Remittance Statement as the invoice number.

28 TOTAL CHARGE

Enter the total of the individual procedure charges listed in column 24F.

[12 INDICATE SPECIAL TESTS FOR EPSDT (SCREENING REQUIREMENTS):

Enter code as appropriate in each box for Special test rendered. Codes for Blocks #11 and #12 are as follows:

A = Normal
B = Abnormal, referred
C = Abnormal, under treatment

Leave Blank if service was not indicated for child's age and health history.

13 INDICATE CATEGORY OF SERVICE:

Place a check in the appropriate box to identify the type of provider submitting this claim. If "other" is checked, the two digit code found in the appropriate provider manual should also be entered in the space provided.

14 REFERRED TO (For EPSDT services only):

If the recipient was referred for further treatment, place a check in the appropriate box. If the referral was to someone other than a physician or dentist, identify the type of provider in the space provided (e.g., optometrist, audiologist) and code appropriately using the following codes:

41	Audiologist	56	Orthopedics	12	Mental Disorders
54	Ophthalmologist	55	Neurology	90	All Other Referrals
51	Optometrist	72	Speech		(Please identify type of provider)

15 DISPOSITION OF CASE (For EPSDT services only):

Check the appropriate box to indicate the disposition of the case.

16 No entry required.

17 PROVIDER NUMBER:

Enter the eight-digit assigned provider number of professional rendering the service.]

SECTION VI - COMPLETION OF INVOICE FORM

29 AMOUNT PAID

Enter the amount received by any other private insurance, DO NOT INCLUDE Medicare. If no health insurance payment amount, leave blank.

30 BALANCE DUE

Enter the amount received from Medicare.

31 SIGNATURE/INVOICE DATE

The actual signature of the provider (not a fascimile) or the provider's appointed representative is required. Stamped signatures are not acceptable.

33 PROVIDER NUMBER

Enter the name and address of the provider submitting the claim. Beside PIN # enter the eight-digit individual Medicaid provider number.

[18 PLACE OF SERVICE:

Enter the place of service code from note 1 of the claim form to indicate the site at which the services were provided.

19 PROCEDURE/SUPPLY DESCRIPTION, PRESCRIPTION:

Enter description of service, supply item furnished, or prescription number for service rendered this patient.

20 DRUG NUMBER:

Enter the 10 digit NDC drug number from the Outpatient Drug List. The first 5 digits are the manufacturers number, the last five digits are the product number.

21 UNITS OF SERVICE (Required):

Enter the number of times this procedure was performed on the recipient on this date. For dental services enter the number of times this procedure was performed on this date. For pharmacy services, enter the drug quantity of each prescription billed.

22 PROCEDURE/SUPPLY CODE (Required):

Enter the five-digit code identifying the service of supply furnished to this recipient.

23 TOOTH ID:

Enter up to 3 tooth identification codes (from Universal Tooth Identification Chart) per line for teeth treated by service billed. If more than 3 teeth were treated complete next line.

24 DIAGNOSIS TREATED:

Enter the applicable number from note 2 (diagnosis treated). Required for all medical services (excludes only dental and drug services).

25 PROCEDURE CHARGES:

Enter the usual and customary charge for the service rendered.]

[26 No entry required.

27 TOTAL CLAIM CHARGE:

Enter the total of lines 1 - 10.

28 HEALTH INSURANCE AMOUNT:

Enter the total amount (if any) received from the patient's health insurance for services billed.

29 AMOUNT FROM MEDICARE:

Enter the total amount received from Medicare for services billed. Attach a copy of the Medicare Explanation of Benefits to claim.

30 PROVIDER NAME:

Enter the name and address of the Primary Care Center performing the services being billed.

31 PROVIDER NUMBER:

Enter the eight-digit Medicaid provider number assigned to the provider listed in block 30.

32 AUTHORIZED SIGNATURE:

The actual signature of the provider or authorized representative is entered here.

33 COUNTY:

No entry required.

~~[34 AREA:~~

~~No entry required.~~

~~35 INVOICE DATE:~~

~~Enter the month, day, and year that the invoice was signed and submitted to Medical Assistance (i.e. November 15, 1988 would be entered 11 15 88).~~

~~36 DATE OF SERVICE:~~

~~Enter the month, day and year (numeric equivalent as block 35) the services were provided. One date of service per claim.~~

~~37 CHARGE DISPOSITION:~~

~~No entry required.~~

~~38 INVOICE NUMBER:~~

~~No entry required.~~

~~39 No entry required.]~~

```
* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
*Claims for covered services must be received by EDS within twelve*
*(12) months from the date of service.  Claims with service dates *
*more than twelve (12) months old can be considered for processing*
*only with appropriate documentation such as one or more of the   *
*following:  Remittance Statements no more than 12 months of age  *
*which verify timely filing, backdated MAID cards, Social Security*
*documents, correspondence describing extenuating circumstances,  *
*Action Sheets, Return to Provider Letters, Medicare Explanation  *
*of Medicare Benefits, etc.                                       *
* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *
```

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

NEW FORM

APPROVED OMB-0938-0008

Appendix VIII

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER	1a. INSURED'S I.D. NUMBER
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	(ID)	

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO / PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes* return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ____ DATE ____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ____

SAMPLE

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO / $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 2. 3. 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	EPSDT Family Plan	H EMG	I COB	J RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED ____ DATE ____	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12/90)
FORM OWCP-1500 FORM RRB-1500
FORM OP 050191

Transmittal #19

APPENDIX VIII

MAP 7 (10/86)

EDS
P.O. Box 2064
Frankfort, KY 40602

COMMONWEALTH OF KENTUCKY
MEDICAL ASSISTANCE STATEMENT
PRIMARY CARE/RURAL HEALTH

Do not write in this area

RECIPIENT LAST NAME	2. FIRST NAME	3. M.I.	4. MEDICAL ASSISTANCE I.D. NUMBER

5. ☐ IF EMERGENCY CHECK BOX	6. If Claim Required A Prior Authorization, Enter The Prior Authorization Number Here	7. If Services Were Provided As A Result of A Screening Exam Referral, Check Box ☐	8. If Patient Was Referred To You, Enter The Name of The Referring Practitioner.
	____ ____ ____ ____		

9. IF PATIENT HAS HEALTH INSURANCE, ENTER THE NAME AND ADDRESS OF COMPANY AND POLICY NUMBER — LEAVE BLANK

10. (1) FIRST DIAGNOSIS:

(2) SECOND DIAGNOSIS:

11. INDICATE SERVICE BY ENTERING APPROPRIATE CODE (SEE MANUAL)
- ☐ General Health Assessment and Patient History
- ☐ Development Assessment
- ☐ Visual Screening
- ☐ Audiometric Screening
- ☐ Dental Screening
- ☐ Urinalysis
- ☐ Tuberculosis Test
- ☐ Hematocrit or Hemoglobin
- ☐ Lead Poisoning
- ☐ Other (Specify)

12. INDICATE SPECIAL TESTS BY ENTERING APPROPRIATE CODE (SEE MANUAL)
- ☐ Assessment and Administration of Vaccines and Immunizations
- ☐ Blood Pressure
- ☐ V.D.R.L.
- ☐ Sickle Cell Test
- ☐ Bacteriuria Screening
- ☐ Other (Specify)

13. INDICATE CATEGORY OF SERVICE
- 41 ☐ Primary Care Center
- ____ ☐ Other (Enter Code)

14. REFERRED TO:
01 ☐ PHYSICIAN 02 ☐ DENTIST ☐ OTHER (SPECIFY) _____

15. DISPOSITION OF CASE:
A ☐ NORMAL VISIT SCHEDULED B ☐ REFERRED FOR TREATMENT

16. Line No.	17. Provider Number	18. Place of Service Note (1)	19. Procedure/Supply Description PRESCRIPTION NUMBER	20. Drug Number	21. Units of Service	22. Procedure Supply Code	23. Tooth ID	24. See Note (2)	25. Procedure Charge	26. LEAVE BLANK
01										
02										
03										
04										
05										
06										
07										
08										
09										
10										

30. PROVIDER NAME AND ADDRESS

31. Provider Number

TOTAL CLAIM CHARGE	27.	39. LEAVE BLANK
AMOUNT FROM HEALTH INSURANCE	28.	
AMOUNT FROM MEDICARE	29.	

32. Authorized Certification and Signature

This is to certify that the foregoing information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the Kentucky Medical Assistance Program. I understand that payment and satisfaction of this claim will be from Federal and State funds, and thay any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

33. COUNTY | 34. AREA

35. INVOICE DATE
Mo. Day Yr.

38. INVOICE NO.
0543752

36. Date of Service
Mo. Day Yr.

NOTE (1) PLACE OF SERVICE CODES
1. Doctor's Office
2. Patient's Home
3. Outpatient Dept. Hospital
4. Inpatient Hospital
5. Skilled Nursing Home
6. Primary Care Center
7. Intermediate Care Facility
8. Independent Laboratory
9. Rural Health Clinics/HMO

NOTE (2)
Enter Diagnosis Treated from Block 10 "1" First "2" Second

37. CHARGE DISPOSITION
☐ Pay
☐ Charge Accumulate

TRANSMITTAL #17

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:427
Incorporation By Reference Of
Primary Care Services Manual

Summary of Incorporated By Reference Material
April 1992

1. The Primary Care Services Manual is used by agency staff and participating providers of the Kentucky Mediciad Program. The manual is being amended to reflect any policy changes which have been promulgated and approved in the appropriate administrative regulation and to show any clarifications of policy or procedure which have been made.

2. Nine (9) pages are being amended by this proposed regulation. The changes are listed below.

3. The Table of Contents is being amended to add, delete and change headings to reflect the correct sections and page contents. These changes have no major impact on policy.

4. Pages 6.1 through 6.5 are being amended to show the new instructions for completing the HCFA 1500 (12/90) billing form. This is a policy change.

5. Appendix VIII is being amended to show the revised HCFA 1500 (12/90) billing form.